

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP () IE () IC	Response Timely Filed? () Yes (x) No
Requestor's Name and Address Jacob Rosenstein, MD 800 West Arbrook Blvd., Suite 150 Arlington, Texas 76015	MDR Tracking No.: M4-03-4697-01
	TWCC No.:
	Injured Employee's Name:
Respondent's Name and Address American Manufacturers Mutual Insurance Company P O Box 162443 Westlake Station Austin, Texas 78716 Box 42	Date of Injury:
	Employer's Name: Petco Animal Supplies, Inc.
	Insurance Carrier's No.: 4650103244

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
07/12/02	07/12/02	63077	\$3,035.00	\$3,035.00

PART III: REQUESTOR'S POSITION SUMMARY

"On page 64 of the TWCC fee guidelines, the multiple procedure reimbursement rule states, '100% for the primary procedure(major procedure reflecting the greatest value).' MAR for Code 63077 at \$3035.00 and it is the primary procedure code. The code in the table is listed in the TWCC fee guidelines and was coded and billed exactly correct according to the TWCC fee guidelines."

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier's response was untimely. Denials listed on the EOBs state, "G-Undundling."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Per the MFG Surgery ground rules (I)(D)(a), the procedure reflecting the greatest value is to be reimbursed at 100% of MAR. CPT code 63077 reflected an amount of \$3035.00 and the other codes billed for the same procedure were not greater than this amount. Per the Global Service Data for Orthopaedic Surgery book 63077 is not global to CPT code 22845 or 22554. Therefore, based on this information reimbursement is recommended.

[illegible]

PART VII: COMMISSION DECISION AND ORDER					
<p>Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to reimbursement in the amount of \$3,035.00. The Division hereby ORDERS the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the requestor within 20-days in receipt of this Order.</p> <p>Ordered by:</p> <table style="width: 100%; margin-top: 20px;"> <tr> <td style="width: 33%; text-align: center; border-top: 1px solid black; padding-top: 10px;"> <div style="border-bottom: 1px solid black; height: 40px; margin-bottom: 5px;"></div> <div>Authorized Signature</div> </td> <td style="width: 33%; text-align: center; border-top: 1px solid black; padding-top: 10px;"> <div style="border-bottom: 1px solid black; height: 40px; margin-bottom: 5px;"></div> <div>Michael Bucklin</div> <div>Typed Name</div> </td> <td style="width: 33%; text-align: center; border-top: 1px solid black; padding-top: 10px;"> <div style="border-bottom: 1px solid black; height: 40px; margin-bottom: 5px;"></div> <div>02/15/05</div> <div>Date of Order</div> </td> </tr> </table>			<div style="border-bottom: 1px solid black; height: 40px; margin-bottom: 5px;"></div> <div>Authorized Signature</div>	<div style="border-bottom: 1px solid black; height: 40px; margin-bottom: 5px;"></div> <div>Michael Bucklin</div> <div>Typed Name</div>	<div style="border-bottom: 1px solid black; height: 40px; margin-bottom: 5px;"></div> <div>02/15/05</div> <div>Date of Order</div>
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PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____